Notice to Employees of Rights Under FMLA

EMPLOYEE RIGHTS AND RESPONSIBILTIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement: FMLA requires the City of Houston to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements: Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the U. S. armed forces in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employers to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections: During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

FMLA Eligibility Requirements: City of Houston employees are eligible if they have worked for the City of Houston for at least one year, and have physically worked 1,250 hours over the previous 12 months prior to the date of the proposed FMLA leave.

Definition of Serious Health Condition: A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave: An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave: The City of Houston requires the exhaustion of appropriate paid leave prior to taking unpaid FMLA leave during the approved leave period. In order to use paid leave for FMLA leave, employees must comply with the City of Houston and their department's normal paid leave policies.

Employee Responsibilities: Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with their department's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities: Employees requesting leave must be informed whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employee must be provided a reason for the ineligibility.

Employees must be informed whether their leave will be designated as FMLA-protected and the amount of leave to be counted against the employee's FMLA leave entitlement. The employee must be notified if it has been determined that the leave is not FMLA-protected.

Unlawful Acts by Employers: FMLA makes it unlawful for any employer to interfere with, restrain, or deny the exercise of any right provided under FMLA, or to discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement: An employee may file a complaint with the U. S. Department of Labor or may bring a private lawsuit against their employer. FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

For additional information, contact the U. S. Department of Labor at 1-866-487-9243 (TTY: 1-877-889-5627), or go to www.wagehour.dol.gov

FMLAeenoticeJanuary2010

CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE REQUEST/NOTICE

Employee Name (first, mi, last) _____ Social Security No. ___/___/___ Employee No. _____

Home Address _____ City _____ State _____ Zip Code _____ Home Phone No. (___) ___-____

Work Phone No. (___) ___-____

☐ Form completed by employee.
☐ Form completed by supervisor based on information provided by employee. Describe circumstances and date information was provided _____.

A "YES" answer to any of the items in the chart below requires that the employer provide the employee with the following: (Employee's initials on line indicate receipt; supervisor's initials indicate distribution to the employee.)

☐ (1) A copy of the U.S. Department of Labor Highlights, FMLA Fact Sheet No. ESA 93-24
☐ (2) A completed Notice to Employee of Responsibilities and Requirements of FMLA Leave Form WH-381 Substitute, Dec 1994
☐ (3) Leave Authorization Request, Revised P.D. Form 206
(4) The following form(s), where applicable, are to be completed and returned to the supervisor:
  ☐ (a) Statement of Family Relationship Form, if the leave request pertains to the employee's spouse, child or parent.
  ☐ (b) Certification of Health Care Provider, Form WH-380 Substitute, Dec. 1994, if the leave request is for a serious health condition of the employee or an employee's covered family member.

Leave is due to the serious health condition of: (Check One) ☐ **Employee** ☐ **Child** ☐ **Spouse** ☐ **Parent**	*YES*	*NO*
1.) Does the condition arise from or require an overnight stay in a hospital, hospice, or residential medical care facility?		
2.) Does the condition make the person unable to work, attend school or perform other regular daily activities for more than 3 consecutive calendar days, and is the person receiving continuing treatment for the condition by or under the supervision of a health care provider during the leave period?		
3.) Is the absence because of an incapacity due to pregnancy or for prenatal care, and is the person receiving continuing treatment for the pregnancy or prenatal care from a health care provider?		
4.) Is this a chronic condition (for example, diabetes, asthma, epilepsy, etc.) for which the person is receiving continuing treatment from a health care provider?		
5.) Is this a permanent or long-term incapacity for which treatment may not be effective (for example, Alzheimer's, severe stroke or terminal stages of a disease) and the person is under the continuing supervision of a health care provider?		
6.) Is the absence needed to receive multiple treatments from, under the supervision of, or on referral by a health care provider, either for restorative surgery after an accident or injury or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment (for example, chemotherapy, radiation, dialysis)?		
7.) Leave is due to birth, placement or parenting. Check One: ☐ Birth and/or care of the child within 12 months of birth ☐ Adoption or foster care placement and/or care within 12 months of placement		

_____ ___/___/___ _____
oyee's Signature Date Department

_____ ___/___/___ _____
or or Designee Signature Date Department

Form B

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

U.S. Wage and Hour Division
(Revised January 2009)

Fact Sheet #28: The Family and Medical Leave Act of 1993

The U.S. Department of Labor's Employment Standards Administration, Wage and Hour Division, administers and enforces the Family and Medical Leave Act (FMLA) for all private, state and local government employees, and some federal employees. Most federal and certain congressional employees are also covered by the law and are subject to the jurisdiction of the U.S. Office of Personnel Management or the Congress. See Fact Sheet 28A.

The FMLA became effective on August 5, 1993 for most employers and entitles eligible employees to take up to 12 weeks of unpaid, job-protected leave in a 12-month period for specified family and medical reasons. Amendments to the FMLA by the National Defense Authorization Act for FY 2008 (NDAA), Public Law 110-181, expanded the FMLA to allow eligible employees to take up to 12 weeks of job-protected leave in the applicable 12-month period for any "qualifying exigency" arising out of the fact that a covered military member is on active duty, or has been notified of an impending call or order to active duty, in support of a contingency operation. The NDAA also amended the FMLA to allow eligible employees to take up to 26 weeks of job-protected leave in a "single 12-month period" to care for a covered servicemember with a serious injury or illness.

EMPLOYER COVERAGE

FMLA applies to all public agencies, including state, local and federal employers, local education agencies (schools), **and** private-sector employers who employed 50 or more employees in 20 or more workweeks in the current or preceding calendar year, including joint employers and successors of covered employers.

EMPLOYEE ELIGIBILITY

To be eligible for FMLA benefits, an employee **must:**

- work for a covered employer;
- have worked for the employer for a total of 12 months;
- have worked at least 1,250 hours over the previous 12 months; and
- work at a location in the United States or in any territory or possession of the United States where at least 50 employees are employed by the employer within 75 miles.

While the 12 months of employment need not be consecutive, employment periods prior to a break in service of **seven** years or more need not be counted unless the break is occasioned by the employee's fulfillment of his or her National Guard or Reserve military obligation (as protected under the Uniformed Services Employment and Reemployment Rights Act (USERRA)), or a written agreement, including a collective bargaining agreement, exists concerning the employer's intention to rehire the employee after the break in service. *See*, special rules for returning reservists under USERRA.

LEAVE ENTITLEMENT

A covered employer must grant an eligible employee up to a total of **12 workweeks** of **unpaid** leave during any 12-month period for one or more of the following reasons:

- for the birth and care of a newborn child of the employee;

- for placement with the employee of a son or daughter for adoption or foster care;
- to care for a spouse, son, daughter, or parent with a serious health condition;
- to take medical leave when the employee is unable to work because of a serious health condition; **or**
- for qualifying exigencies arising out of the fact that the employee's spouse, son, daughter, or parent is on active duty or call to active duty status as a member of the National Guard or Reserves in support of a contingency operation.

A covered employer also must grant an eligible employee who is a spouse, son, daughter, parent, or next of kin of a current member of the Armed Forces, including a member of the National Guard or Reserves, with a serious injury or illness up to a total of **26 workweeks** of **unpaid** leave during a "single 12-month period" to care for the servicemember. *See* Fact Sheet 28A for specific information regarding military family leave.

Spouses employed by the same employer are limited in the **amount of** family leave they may take for the birth and care of a newborn child, placement of a child for adoption or foster care, or to care for a parent who has a serious health condition to a combined total of 12 weeks (or 26 weeks if leave to care for a covered servicemember with a serious injury or illness is also used). Leave for birth and care, or placement for adoption or foster care, must conclude within 12 months of the birth or placement.

Under some circumstances, employees may take FMLA leave intermittently – taking leave in separate blocks of time for a single qualifying reason – or on a reduced leave schedule – reducing the employee's usual weekly or daily work schedule. When leave is needed for planned medical treatment, the employee must make a reasonable effort to schedule treatment so as not to unduly disrupt the employer's operation. If FMLA leave is for birth and care, or placement for adoption or foster care, use of intermittent leave is subject to the employer's approval.

Under certain conditions, employees **or** employers may choose to "substitute" (run concurrently) accrued **paid** leave (such as sick or vacation leave) to cover some or all of the FMLA leave. An employee's ability to substitute accrued paid leave is determined by the terms and conditions of the employer's normal leave policy.

"**Serious health condition**" means an illness, injury, impairment, or physical or mental condition that involves either:

- Inpatient care (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical-care facility, including any period of incapacity (*i.e.*, inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care; **or**

- Continuing treatment by a health care provider, which includes:

  (1) A period of incapacity lasting more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that **also** includes:
  - treatment two or more times by or under the supervision of a health care provider (*i.e.*, in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); **or**
  - one treatment by a health care provider (*i.e.*, an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (*e.g.*, prescription medication, physical therapy); **or**

  (2) Any period of incapacity related to pregnancy or for prenatal care. A visit to the health care provider is not necessary for each absence; **or**

(3) Any period of incapacity or treatment for a chronic serious health condition which continues over an extended period of time, requires periodic visits (at least twice a year) to a health care provider, and may involve occasional episodes of incapacity. A visit to a health care provider is not necessary for each absence; **or**

(4) A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. Only supervision by a health care provider is required, rather than active treatment; **or**

(5) Any absences to receive multiple treatments for restorative surgery or for a condition that would likely result in a period of incapacity of more than three days if not treated.

MAINTENANCE OF HEALTH BENEFITS

A covered employer is required to maintain group health insurance coverage for an employee on FMLA leave whenever such insurance was provided before the leave was taken and on the same terms as if the employee had continued to work. If applicable, arrangements will need to be made for employees to pay their share of health insurance premiums while on leave. In some instances, the employer may recover premiums it paid to maintain health coverage for an employee who fails to return to work from FMLA leave.

JOB RESTORATION

Upon return from FMLA leave, an employee must be restored to the employee's original job, or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment. An employee's use of FMLA leave cannot result in the loss of any employment benefit that the employee earned or was entitled to before using FMLA leave, nor be counted against the employee under a "no fault" attendance policy. If a bonus or other payment, however, is based on the achievement of a specified goal such as hours worked, products sold, or perfect attendance, and the employee has not met the goal due to FMLA leave, payment may be denied unless it is paid to an employee on equivalent leave status for a reason that does not qualify as FMLA leave.

An employee has no greater right to restoration or to other benefits and conditions of employment than if the employee had been continuously employed.

NOTICE AND CERTIFICATION

Employee Notice

Employees seeking to use FMLA leave are required to provide 30-day advance notice of the need to take FMLA leave when the need is foreseeable and such notice is practicable. If leave is foreseeable less than 30 days in advance, the employee must provide notice as soon as practicable – generally, either the same or next business day. When the need for leave is not foreseeable, the employee must provide notice to the employer as soon as practicable under the facts and circumstances of the particular case. Absent unusual circumstances, employees must comply with the employer's usual and customary notice and procedural requirements for requesting leave.

Employees must provide sufficient information for an employer reasonably to determine whether the FMLA may apply to the leave request. Depending on the situation, such information may include that the employee is incapacitated due to pregnancy, has been hospitalized overnight, is unable to perform the functions of the job, and/or that the employee or employee's qualifying family member is under the continuing care of a health care provider.

When an employee seeks leave for a FMLA-qualifying reason for the **first** time, the employee need not expressly assert FMLA rights or even mention the FMLA. When an employee seeks leave, however, due to a FMLA-qualifying reason for which the employer has previously provided the employee FMLA-protected leave, the employee **must** specifically reference either the qualifying reason for leave or the need for FMLA leave.

Employer Notice

Covered employers must post a notice approved by the Secretary of Labor explaining rights and responsibilities under FMLA. An employer that willfully violates this posting requirement may be subject to a fine of up to $110 for each separate offense. Additionally, employers must either include this general notice in employee handbooks or other written guidance to employees concerning benefits, or must distribute a copy of the notice to each new employee upon hiring.

When an employee requests FMLA leave or the employer acquires knowledge that leave may be for a FMLA purpose, the employer must notify the employee of his or her eligibility to take leave, and inform the employee of his/her rights and responsibilities under FMLA. When the employer has enough information to determine that leave is being taken for a FMLA-qualifying reason, the employer must notify the employee that the leave is designated and will be counted as FMLA leave.

Certification

Employers may require that an employee's request for leave due to a serious health condition affecting the employee or a covered family member be supported by a certification from a health care provider. An employer may require second or third medical opinions (at the employer's expense) and periodic recertification of a serious health condition. An employer may use a health care provider, a human resource professional, a leave administrator, or a management official – but not the employee's direct supervisor – to authenticate or clarify a medical certification of a serious health condition. An employer may have a uniformly-applied policy requiring employees returning from leave for their own serious health condition to submit a certification that they are able to resume work. If reasonable safety concerns exist, an employer may, under certain circumstances, require such a certification for employees returning from intermittent FMLA leave.

UNLAWFUL ACTS

It is unlawful for any employer to interfere with, restrain, or deny the exercise of any right provided by FMLA. It is also unlawful for an employer to discharge or discriminate against any individual for opposing any practice, or because of involvement in any proceeding, related to FMLA.

ENFORCEMENT

The Wage and Hour Division investigates complaints. If violations cannot be satisfactorily resolved, the U.S. Department of Labor may bring action in court to compel compliance. Individuals may also be able to bring a private civil action against an employer for violations.

OTHER PROVISIONS

Special rules apply to employees of local education agencies. Generally, these rules apply to intermittent leave or when leave is required near the end of a school term.

Salaried executive, administrative, and professional employees of covered employers who meet the Fair Labor Standards Act (FLSA) criteria for exemption from minimum wage and overtime under Regulations, 29 CFR Part 541, do not lose their FLSA-exempt status by using any unpaid FMLA leave. This special exception to the "salary basis" requirements for FLSA's exemption extends only to an "eligible" employee's use of leave required by FMLA.

For additional information, visit our Wage and Hour Division Website: http://www.wagehour.dol.gov and/or call our toll-free information and helpline, available 8 a.m. to 5 p.m. in your time zone, 1-866-4USWAGE (1-866-487-9243).

This publication is for general information and is not to be considered in the same light as official statements of position contained in the regulations.

U.S. Department of Labor
Frances Perkins Building
200 Constitution Avenue, NW
Washington, DC 20210

1-866-4-USWAGE
TTY: 1-866-487-9243
Contact Us

Appendix B

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181
Expires: XX/XX/XXX

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

CONTINUED ON NEXT PAGE

FORM E – EMPLOYEE'S SERIOUS HEALTH CONDITION

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___No ___Yes. If so, dates of admission:

_____

Date(s) you treated the patient for condition:

_____

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___Yes.

Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

_____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

If so, identify the job functions the employee is unable to perform:

_____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

_____

_____

_____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____.

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____ Yes. If so, explain:

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH SUFFICIENT ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Appendix B

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1215-0181
Expires: XX/XX/XXX

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

_____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

FORM E – FAMILY MEMBER

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address:_____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax:(_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission: _____

   Date(s) you treated the patient for condition: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ____ Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____ No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

PART B. AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by this employee seeking leave may include assistance with basic medical, hygiene, nutritional, safety or transportation needs, or the provision of physical or psychological care.

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? ___ No ___ Yes.

   Explain the care needed by the patient and why such care is medically necessary: _____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   Explain the care needed by the patient, and why such care is medically necessary: _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ___ No ___ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ____ day(s) per episode

Does the patient need care during these flare-ups? ____ No ____ Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE
STATEMENT OF FAMILY RELATIONSHIP

If you are requesting FMLA leave to care for a spouse, child or parent with a serious health condition, or for the birth, adoption or foster care placement of a child and/or to care for the child within 12 months of the birth or placement, you must complete the appropriate section of this form, sign and date on the reverse side, and submit the form to your supervisor. Pursuant to the Family and Medical Leave Act of 1993, the City may require supporting documentation.

_____ _____/_____/_____ _____
Employee Name (first, mi, last) Social Security No. Employee No.

_____ _____ _____ (____)_____-_____
Home Address City State Zip Code Home Phone No.

SPOUSE: A husband or wife as defined or recognized under state law. The State of Texas recognizes a common law marriage, but does not recognize a domestic partnership.

CHILD: A biological, adopted, or foster care son or daughter; a stepson or stepdaughter, a legal ward, or the son or daughter of an employee standing ***in loco parentis****, and who is either under age 18, or is age 18 or older and incapable of self-care because of mental or physical disability.

PARENT: A biological mother or father, or an individual who stands or stood ***in loco parentis**** to an employee when the employee was a child. The term does not include a parent-in-law.

* Persons who are ***in loco parentis*** include those with day-to-day responsibilities to care for and financially support a child, or, in the case of an employee, who had such responsibility for the employee when the employee was a child. A biological or legal relationship is not necessary.

Part I

☐ The employee's request for FMLA leave pertains to the employee's spouse. Complete (a) or (b).

(a) Spouse's Name (last, first, mi) _____
(b) If the relationship is by common-law marriage, read and complete the following statement.

I, the undersigned, am married, but the marriage exists without there having been a ceremonial marriage or recorded license. I understand that under the laws of Texas, such a marriage is valid only if (1) neither of us has a prior legal impediment or bar to marriage, such as a previous marriage which has not been terminated; (2) both of us do, in fact, intend to be husband and wife; (3) we have lived together as husband and wife; and, (4) we hold ourselves out to the public as husband and wife. The following information is given under oath:

Spouse's Name (last, first, mi) _____

Date when parties commenced a relationship as husband and wife _____/_____/_____.

List the names, addresses and telephone numbers of at least two persons who are unrelated to either you or your spouse and who will confirm that they consider you to be husband and wife. The City is authorized to contact the named persons for such confirmation.

_____ _____ _____ _____ _____ (____)_____-_____
Name Address City State Zip Code Phone No.

_____ _____ _____ _____ _____ (____)_____-_____
Name Address City State Zip Code Phone No.

Form F

Part II

☐ The employee's request for FMLA leave **(pertains to the employee's child)**. Complete (a) or (b).

(a) Child's Name (Last, First, MI) _____

Date of Birth: ____/____/____ Place of Birth: _____

(b) If the relationship with the person is ***in loco parentis***, read and complete the following statement:

I, the undersigned, have an ***in loco parentis*** relationship with the person named in **Part II** above.

Explanation of ***in loco parentis*** relationship: _____

_____

_____

_____

Part III

☐ The employee's request for FMLA leave pertains to the **(employee's parent)** (not parent-in-law). Complete (a) or (b).

(a) Parent's Name (last, first, mi) _____

(b) If the relationship with the person is ***in loco parentis***, read and complete the following statement:

I, the undersigned, have an ***in loco parentis*** relationship with the person named in **Part III** above.

Explanation of ***in loco parentis*** relationship: _____

_____

_____

_____

I certify that the information provided above is true and correct. I understand that if I provide false or misleading information, I may be denied FMLA leave and related benefits and receive discipline up to and including indefinite suspension.

_____ ____/____/____

Employee's Signature Date

Form F

REVISED P.D. FORM 206
NOVEMBER 17, 1982

CITY OF HOUSTON
Leave Authorization Request

FORM DATA - FILL IN APPROPRIATE INFORMATION				
EMPLOYEE NAME	Last Name	First Name	Middle Initial	EMPLOYEE NUMBER
DEPARTMENT		DIVISION		
DATE SUBMITTED	PREPARED BY	DATE OF LAST REQUEST		REASON
		—		

ACTION DATA - FILL IN APPROPRIATE INFORMATION												
	ACTION	BEGIN				END			NUMBER OF WORK DAYS			HRS
	VACATION								DAYS —	HOLIDAY —		
	⇒ Leave pursuant to the Family and Medical Leave											
	SICK LEAVE								—			
	SICK LEAVE EXTENSION								*SECT 12-169, PAR F.1 CIVIL SERVICE CODE OF ORDINANCE			
	ABSENT								—			
	FLOATING HOLIDAY								—			
	DEATH IN FAMILY								—			
	COMP. TIME								—			
	JURY DUTY								*ATTACH SUMMONS			
	MILITARY LEAVE								*ATTACH ORDERS			
	OTHER (EXPLAIN BELOW)								—			
	⇒ Leave pursuant to the Family and Medical Leave											

SIGNATURE DATA - FILL IN APPROPRIATE INFORMATION			
EMPLOYEE ▶		DATE	
SUPERVISOR ▶		DATE	
APPROVING ▶		DATE	

*Supporting document(s) must accompany this form

TYPE OF ABSENCE—CHECK ONE: ☐ *SCHEDULED* ☐ *UNSCHEDULED*

MEDICAL PROVIDED—CHECK ONE: ☐ *YES* ☐ *NO*

OTHER NECESSARY DOCUMENTATION (JURY DUTY, FUNERAL, etc.) PROVIDED—CHECK ONE: ☐ *YES* ☐ *NO*

- ☐ Doctor's Appointment Verification
- ☐ Return to Duty Certification
- ☐ Reduced/Intermittent Leave Schedule

CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE

EMPLOYEE AUTHORIZATION FOR CLARIFICATION/AUTHENTICATION OF MEDICAL CERTIFICATION

I, _____, authorize the City of Houston's health care representative to communicate with the health care provider named below for purposes of clarifying and/or verifying the authenticity of the FMLA medical certification dated _____/_____/_____, as specifically authorized under § 825.307 (a) of the Department of Labor Final Rule on the Family and Medical Leave Act of 1993. I understand that no additional information other than that indicated on the medical certification will be requested by the City's health care representative or given by my health care provider, and that my health care provider will only clarify and/or authenticate the medical certification.

_____ _____/_____/_____

Employee's Signature Date

Health Care Provider's Name: _____

(Please Print)

Telephone Number: (_____)_____-_____

Fax Number: (_____)_____-_____

Form I

CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE

FITNESS FOR DUTY CERTIFICATION

Employee Name (first, mi, last) _____ Social Security No. ____/____/____ Employee No. _____

Employee Address _____ City _____ State _____ Zip Code _____

Job Title _____

INSTRUCTIONS TO HEALTH CARE PROVIDER

The above individual desires to return to work after a Family and Medical Leave for his/her own serious health condition. Please complete and sign this form.

Is the employee ready to return to work duties?

CHECK ONE

☐ Regular duty with no restrictions ____/____/____
Return to work date

☐ Duty with the following restrictions

____/____/____ until ____/____/____
Return to work date Date restrictions end

_____

_____

☐ No duty; the employee is not yet released to return to work.

_____ ____/____/____
Health Care Provider's Signature Date

_____
Health Care Provider's Name (please print)

_____
Health Care Provider's Area of Specialty

_____
Address City State Zip Code

(____)____-____ (____)____-____
Telephone Number Fax Number

Form J

CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE
SCHEDULE FOR REDUCED/INTERMITTENT LEAVE

Employee Name (first, mi, last) _____ Social Security No. ___/___/___ Employee No. _____

Employee Address _____ City _____ State _____ Zip Code _____

SECTION I - EMPLOYEE'S CURRENT SCHEDULE

SHIFT Begins _____ am/pm Off-days _____

Ends _____ am/pm _____

Describe in detail if non-standard shift:

_____

_____

SECTION II - REDUCED/INTERMITTENT LEAVE SCHEDULE

NOTE: Attach a completed Certification of Health Care Provider, Form WH-380, explaining the medical necessity for the reduced schedule or intermittent leave.

The employee's current work schedule will be changed during the applicable FMLA period to a:

☐ Reduced leave schedule from ___/___/___ to ___/___/___. Describe schedule in detail:

_____

_____

☐ Intermittent leave schedule from ___/___/___ to ___/___/___. Describe schedule in detail, including hours/days during which FMLA leave will be utilized.

_____

_____

The employee and the Department have mutually agreed on Section II that allows reduced/intermittent leave during the applicable FMLA leave period.

_____ ___/___/___
Employee's Signature Date

_____ ___/___/___
Supervisor/Department Coordinator Signature Date

Form K

CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE
HEALTH BENEFITS CONTINUATION BIWEEKLY PREMIUM SCHEDULE
(PRINT OR TYPE ONLY)

Name: _____ _____ _____ _____ - _____ - _____
Last First MI. Social Security Number

_____ _____ _____ _____ ( ) _____ - _____
Address City St. Zip Code Home Phone Number

_____ _____ _____ / _____ / _____
Employee Number Department Name Date of Last City Payroll Check Received

CONTINUED GROUP HEALTH PLAN INSURANCE COVERAGE

(Note: Workers' Compensation does not pay for benefits while an employee is out on injury.)

I acknowledge that while I am on FMLA, I am responsible for my share of the premium payment for my group health plan coverage and the premiums for continuation of any other benefit(s) I wish to maintain. I understand that failure to make this payment within thirty (30) days of the due date will result in termination of health plan and other coverage retroactive to the date for which my last premium was paid. If coverage is terminated due to non-payment or untimely premium payment, I understand that my health plan and other coverage will be restored without requalification upon my return to work and my completion of enrollment forms on the same terms as prior to my leave.

SECTION I - ELECTION

I am paying for the period of _____, and I agree to pay for my benefits below (check applicable boxes):

Please use chart on the reverse of this form to calculate your Basic Life Insurance Premium of one times your annual salary.

(BIWEEKLY PREMIUMS)	MEDICAL PREMIUM	DENTAL PREMIUM	BASIC LIFE PREMIUM	TOTAL PREMIUM
CIGNA LIMITED PLAN				
Employee only	{ } $ 23.93	{ } $ 4.50 DMO		
(Medical Tobacco Rate)	{ } $ 36.43	{ } $ 15.79 INDEMNITY	$ _____	$ _____
Employee + Spouse	{ } $ 95.73	{ } $ 10.34 DMO		
(Medical Tobacco Rate)	{ } $ 108.23	{ } $ 36.33 INDEMNITY	$ _____	$ _____
Employee + Child(ren)	{ } $ 71.79	{ } $ 10.34 DMO		
(Medical Tobacco Rate)	{ } $ 84.29	{ } $ 36.33 INDEMNITY	$ _____	$ _____
Employee + Family	{ } $ 143.59	{ } $ 14.18 DMO		
(Medical Tobacco Rate)	{ } $ 156.09	{ } $ 49.75 INDEMNITY	$ _____	$ _____
CIGNA OPEN ACCESS PLAN				
Employee only	{ } $ 37.23	{ } $ 4.50 DMO		
(Medical Tobacco Rate)	{ } $ 49.73	{ } $ 15.79 INDEMNITY	$ _____	$ _____
Employee + Spouse	{ } $ 148.91	{ } $ 10.34 DMO		
(Medical Tobacco Rate)	{ } $ 161.41	{ } $ 36.33 INDEMNITY	$ _____	$ _____
Employee + Child(ren)	{ } $ 111.68	{ } $ 10.34 DMO		
(Medical Tobacco Rate)	{ } $ 124.18	{ } $ 36.33 INDEMNITY	$ _____	$ _____
Employee + Family	{ } $ 223.36	{ } $ 14.18 DMO		
(Medical Tobacco Rate)	{ } $ 235.86	{ } $ 49.75 INDEMNITY	$ _____	$ _____
CIGNA CONSUMER DRIVEN PLAN				
Employee only	{ } $ 13.82	{ } $ 4.50 DMO		
(Medical Tobacco Rate)	{ } $ 26.32	{ } $ 15.79 INDEMNITY	$ _____	$ _____
Employee + Spouse	{ } $ 55.31	{ } $ 10.34 DMO		
(Medical Tobacco Rate)	{ } $ 67.81	{ } $ 36.33 INDEMNITY	$ _____	$ _____
Employee + Child(ren)	{ } $ 41.48	{ } $ 10.34 DMO		
(Medical Tobacco Rate)	{ } $ 53.98	{ } $ 36.33 INDEMNITY	$ _____	$ _____
Employee + Family	{ } $ 82.96	{ } $ 14.18 DMO		
(Medical Tobacco Rate)	{ } $ 95.46	{ } $ 49.75 INDEMNITY	$ _____	$ _____

Voluntary Life Insurance with Standard and/or Met Life should also be included in the total premium amount. Enter your biweekly premium here: Met Life $_____ Standard $ _____.

TOTAL AMOUNT ENCLOSED: $_____

SECTION II - ELECTION

☐ I elect **NOT** to continue my group health plan coverage or any other benefit coverage while on unpaid FMLA.

Premiums must be paid by **CASHIERS CHECK OR MONEY ORDER ONLY**. Payment will be made payable to: **City of Houston Health Benefits**. Premium payments must be in the **Human Resources Department, Benefits Division, LWOP Section, 611 Walker, 4th Fl., Houston, TX 77002,** by the first (1st) and fifteenth (15th) of the month. A copy of this form must be attached to your payment. (Monthly payments can also be made.)

I have reviewed and understand my responsibilities regarding my portion of the premium payments for group health plan insurance coverage and other benefits coverage while I am on Family Medical Leave.

Signature: _____ Date: _____/_____/_____

BASIC LIFE INSURANCE

FORMULA FOR CALCULATING BASIC LIFE PREMIUM

STEP 1.)

Enter your biweekly base pay and multiply it by twenty-six (26) to arrive at your annual salary. Take your annual salary amount and round it to the nearest thousand (example: Annual salary $22,550.55 = nearest thousand is $23,000). Divide nearest amount by one thousand to arrive at value amount (*).

_____	x 26 =	_____	=	_____	÷ 1,000 =	(*) _____
Biweekly Base Pay		1 Times Annual Salary		Round Salary to nearest Thousand		Value Amount

STEP 2.)

Carry value amount to this space (*) and multiply by sixteen cents (.05). This is your total monthly Basic Life Premium. Divide your total monthly basic life premium by two (2). This is your Basic Life Biweekly Premium. ***(Place this amount on Basic Life column on reverse side.)***

(*) _____	x .108 =	_____	÷ 2 =	_____
Value Amount		Total Monthly Basic Life Premium		Basic Life Biweekly Premium

Please carry Basic Life Biweekly Premium to the reverse side of this form for calculation with your other benefits.

Other Benefits Coverage: AFLAC (American Family Life Assurance Company)

Your AFLAC supplemental insurance policy (ies) may also be maintained by:

- Informing your Department that you wish to continue premiums for AFLAC.
- Making premium payments for each policy that you may have.
- Payments for AFLAC will be made along with your benefits payment.

Payments will be made payable to AFLAC by a separate money order or cashier check. One money order or cashier check may be used to pay for all AFLAC policies. Payments for AFLAC will be made with your medical, dental, and life insurance payment.

If you have questions or need any assistance regarding your benefits or calculating your premiums, please contact the Benefits Office at (713) 837-9400.

Appendix F to Part 825—[Reserved]

Appendix G to Part 825—Certification of Qualifying Exigency for Military Family Leave (Form WH-384)

Appendix G

Certification of Qualifying Exigency For Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1215-0181
Expires: XX/XX/XXXX

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.309.

Employer name: _____

Contact Information: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 C.F.R. § 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: _____
First Middle Last

Name of covered military member on active duty or call to active duty status in support of a contingency operation:

_____
First Middle Last

Relationship of covered military member to you: _____

Period of covered military member's active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following:

___ A copy of the covered military member's active duty orders is attached.
___ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
___ I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

FORM M-QE

PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

_____

_____

_____

_____

_____

_____

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached. ___ Yes ___ No ___ None Available

PART B: AMOUNT OF LEAVE REQUESTED

1. Approximate date exigency commenced: _____

   Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of absence:

   _____.

3. Will you need to be absent from work periodically to address this qualifying exigency? ___No ___Yes.

   Estimate schedule of leave, including the dates of any scheduled meetings or appointments:_____

   _____

   _____

   _____

   Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours ____ day(s) per event.

CONTINUED ON NEXT PAGE

PART C

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

Email: _____

Describe nature of meeting: _____

_____

_____

_____

_____

_____

_____

_____

_____

PART D

I certify that the information I provided above is true and correct.

_____ _____

Signature of Employee Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**

Appendix H to Part 825—Certification for Serious Injury or Illness of Covered Servicemenber for Military Family Leave (Form WH-385)

Appendix H

Certification for Serious Injury or Illness of Covered Servicemember -- for Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181
Expires: XX/XX/XXX

Notice to the EMPLOYER INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

SECTION I: For Completion by the EMPLOYEE or the COVERED SERVICEMEMBER from whom the Employee is Requesting Leave INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

SECTION II: For Completion by the UNITED STATES DEPARTMENT OF DEFENSE (DOD) HEALTH CARE PROVIDER or a HEALTH CARE PROMOTRA (this refers to a United States Department of Veterans Affairs (VA) health care provider, a DOD TRICARE network authorized private health care provider, or a DOD non-network TRICARE authorized private health care provider) INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

FORM M-SHC

Certification for Serious Injury or Illness of Covered Servicemember - - for Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

U.S. Wage and Hour Division

SECTION I: For Completion by the EMPLOYER and/or the COVERED SERVICEMEMBER for whom the Employee is Requesting Leave (This section must be completed first before any of the below sections can be completed by a health care provider.)

PART A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for covered servicemember):

_____

Name of Employee Requesting Leave to Care for Covered Servicemember:

_____
First Middle Last

Name of Covered Servicemember (for whom employee is requesting leave to care):

_____
First Middle Last

Relationship of Employee to Covered Servicemember Requesting Leave to Care:
☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

PART B: COVERED SERVICEMEMBER INFORMATION

(1) Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves? ___Yes ____No

If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to:

_____

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ___Yes ___No If yes, please provide the name of the medical treatment facility or unit:

_____

(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? ____Yes ____No

PART C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the Care to Be Provided to the Covered Servicemember and an Estimate of the Leave Needed to Provide the Care:

_____

SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. **If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).** (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider: _____

Telephone: ( ) _____ Fax: ( ) _____ Email: _____

PART B: MEDICAL STATUS

(1) Covered Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

☐ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **(SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces? ____ Yes ____ No

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ____Yes ___No. If yes, please describe medical treatment, recuperation or therapy:

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? ___ Yes ___ No
If yes, estimate the beginning and ending dates for this period of time: _____

(2) Will the covered servicemember require periodic follow-up treatment appointments?
___ Yes ___ No If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ____Yes _____No

(4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? ____Yes ____No If yes, please estimate the frequency and duration of the periodic care:

_____

_____

Signature of Health Care Provider: _____ **Date:** _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**

[FR Doc. E8–26577 Filed 11–14–08; 8:45 am]
BILLING CODE 4510–27–C

FAMILY AND MEDICAL LEAVE
TRANSMITTAL MEMO

Employee Name (first, mi, last)	Social Security No.	Employee No.
	___/___/___	

Department FMLA Representative	Date
	___/___/___

This correspondence is provided to inform you of your rights and responsibilities pursuant to the Family and Medical Leave Act (FMLA). In that regard, attached are the following as checked:

☐		Family & Medical Leave Transmittal Memo
☐	A.	Notice to Employees of Rights Under FMLA
☐	B.	Family and Medical Leave Request/Notice
☐	C.	U.S. Department of FMLA Fact Sheet #28: The Family and Medical Leave Act of 1993
☐	D.	Notice to Employee of Eligibility and Rights & Responsibilities of FMLA Leave, Form WH-381
☐	E.	Certification of Health Care Provider, U.S. Department of Labor Form WH-380-E for employee; or
☐	E.	Certification of Health Care Provider, U.S. Department of Labor Form WH-380-E for family member
☐	F.	Statement of Family Relationship
☐	G.	Family and Medical Leave Designation Notice, Form WH-382
☐	H.	Leave Authorization Request, Revised P.D. Form 206
☐	I.	Employee Authorization for Clarification/Authentication of Medical Certification
☐	J.	Fitness for Duty Certification
☐	K.	Schedule for Reduced/Intermittent Leave
☐	L.	Health Benefits Continuation
☐	M-QE.	Certification of Qualifying Exigency for Military Family Leave, WH-384
☐	M-SHC.	Certification for Serious Injury or Illness of Covered Servicemember – for Military Family Leave, WH-385

Only the documents that are (or may be) applicable at this time have been provided.

Please read these forms and documents carefully and follow the instructions. If you use leave pursuant to the FMLA, your appropriate accrued paid leave (vacation, sick, donated sick, and/or personal leave days granted under the City's Plan) shall be used concurrently with FMLA leave. Unpaid FMLA leave shall be used only after your applicable paid leave is exhausted.

If you have any questions regarding the Family and Medical Leave Act, please contact your Department FMLA representative.

I acknowledge receipt of noted document(s)

Employee's Signature	Department FMLA Coordinator's Signature

cc: _____

Employee's Supervisor or Human Resources Liaison